INSTRUCTIONS FOR COMPLETING INITIAL APPLICATION/ANNUAL REPORT FOR HOME HEALTH AGENCY LICENSE

A. Provide the full legal name and address of agency **as it should appear on the license.** Include the full 9 digit zip code, telephone number, fax number and e-mail address if available.

B. Identify the person designated by the governing body to be responsible for the daily management of the agency (Administrator).

C. Indicate the discipline of the person listed in Item B. If the administrator is a health professional other than an RN, please specify the discipline (e.g. physical therapist). If the administrator is not an "appropriate qualified health professional" as defined by KAR 28-51-100(c), then check "other" and include the requested information.

D. Indicate the actual number of home health visits performed by the agency during the calendar year prior to the completion of the annual report. **Do not** include visits associated with "Other" services as identified in Item H. If services are performed on an hourly basis, compute the number of visits on the basis that four hours represent one visit. County or regional public health departments should not include county home visits that are public health services as determined by the Secretary of Health and Environment.

E. If the agency is making an initial application for license, check the space preceding "Initial Application" and include payment of the initial license fee of **$100.00**. If the agency is undergoing a change of ownership, check the appropriate space and include payment of **$100.00** license fee.

For annual reports, check the number of visits corresponding the number of home health visits recorded in Section D, above, and submit payment for the fee shown to the right of this number.

F. Indicate the geographic extent of the agency's operation. Indicate whether the agency provides services in less than an entire county (such as a city or a portion of a county),within a single county, or in more than one county by checking the space preceding the appropriate geographic category. Identify all areas in which service is provided by the agency.

If service is less than county-wide, list municipalities or sections of the county served. If service is provided to a single or multiple county area, list the counties in which services are provided and identify any counties which are in another state. Please note establish branch offices shell be with in 100 miles of the parent location.

G. List the complete telephone number, address (including street, city, state, zip and name) for each branch office which is to be included in the license for which the agency is applying.

H. Indicate all home health services provided by the agency.

I. Give the legal name of the organization that controls or owns this agency.

J. Check the box preceding the appropriate type of entity status from Item I.

K. Complete the boxes below with the information about the disclosing entity.

L. Accreditation for Certified HHAs / CLIA Information, or N/A.

BUREAU OF CHILD CARE & HEALTH FACILITIES

INITIAL APPLICATION/ANNUAL REPORT FOR **HOME HEALTH AGENCY** LICENSE

(PLEASE READ AND FOLLOW THE ENCLOSED INSTRUCTIONS CAREFULLY.)

A. Name of agency: _____ E mail _____

Street City County Zip Code 9-digit Phone No. Fax No.

B. Name and address of Administrator: _____

Street City Zip Code 9-digit Phone No. Fax No.

C. Discipline of Administrator: ___ RN ___ Other health professional: (specify) _____
Other (Please attach documentation of health care education and experience.)

D. Number of Home Visits Made During Previous Calendar Year: _____

E. Fee Schedule: _____ Initial Application: $100.00 _____ Change of Ownership: $100.00
_____ Annual Report: (see below)

	Visits	Fee		Visits	Fee
___	0 - 500	$25.00	___	5,001 - 6,000	$330.00
___	501 - 1,000	$60.00	___	6,001 - 7,000	$380.00
___	1,001 - 2,000	$120.00	___	7,001 - 8,000	$440.00
___	2,001 - 3,000	$170.00	___	8,001 - 10,000	$490.00
___	3,001 - 4,000	$220.00	___	10,001 - 20,000	$550.00
___	4,001 - 5,000	$280.00	___	Over 20,000	$580.00

F. Geographic Area Covered by Agency Operation:

___ Less than County-wide ___ Single County ___ Multi-county

List counties served: _____

G. Branch Offices:

Telephone Numbers Branch Location (Street Address, City, State, Zip and Name if different.)

_____ _____

_____ _____

H. Services Provided by Agency: (Indicate with a **T**)

___	Nursing Care	___	Physical Therapy
___	Speech Therapy	___	Occupational Therapy
___	Medical Social Services	___	Respiratory Therapy
___	Home Health Aide	___	Nutritional or Dietetic Consulting
___	Attendant Care Services	___	Other (specify):

AGENCY USE ONLY

**********DO NOT WRITE BELOW THIS LINE**********

LICENSE EFFECTIVE DATE: _____ **AGENCY ID #:** _____

ANNUAL REPORT DUE: _____ **APPROVED BY:** _____

I. Disclosing Entity's Name: _____Address _____ City _____

J. Type of Entity ❝ 1. Sole Proprietorship ❝ 2. Partnership ❝ 3. Joint Venture
❝ 4. Corporation for profit ❝ 5. Corporation not for profit

❝ 6. Government - Type _____ ❝ 7. Other (Explain)_____ ❝ 8. Limited Liability Company

K. Complete the Boxes below with the Information as Follows for the Disclosing Entity Listed on Line I Above.

1. List the name (s) and address(es) of each person who has any direct or indirect ownership of **10 percent** or more in entity listed above.

2. List each person who is the owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by such facility or any of the property or assets of such facility.

3. If the disclosing entity is organized as a corporation, attach a list showing the names and address of each officer and director.

4. If the disclosing entity is organized as a limited partnership or limited liability company, please describe each limited liability for each 10 percent owner, and for all general partners.

5. If the disclosing entity is a governmental unit, attach a list showing the names and addresses of each responsible official (i.e., county commissioner).

INDICATE WITH "X"					INDIVIDUAL NAME	ADDRESS	CITY	STATE
1.OWNER	2.MORTGAGOR	3.DIRECTORS/OFFICERS	4.LIMITED LIABILITY Describe for each limited partnership & LLC the limited liability for each 10 % owner, and for all general partners.	5.ELECTED OFFICIALS				

L. Are you an Accredited HHA? _____ **Show attachment for request of deemed status**
Are you CLIA wavered or certified? _____ CLIA #_____

The following is the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual, or organization in the operation of the agency by the disclosing entity.

_____ _____
Signature and Title Print Name

_____ _____
Telephone No. Date

Return To: Kansas Department of Health and Environment
Bureau of Child Care & Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1365
Phone: 785-296-1240 Fax: 785-291-3419

HHA301 (Rev. 07/05)